Central
LOCAL HEALTH INTEGRATION NETWORK

Building a Better Health Care System

Exploring New Frontiers, Embracing a Promising Future

Central **LHIN – 2005/06 Annual Report**

Ontario

Introducing Local Health Integration Networks (LHINs)

Local Health Integration Networks (LHINs) are not-for-profit organizations created to plan, coordinate, integrate and fund health services within specific geographic areas. There are 14 LHINs across Ontario. They were created to improve local access to health services in the province.

LHINs were built on the belief that a community's health care needs and priorities can best be determined by people who live in the area, who possess an intrinsic understanding of local needs. LHINs have ushered in a transformation of the way Ontarians will regard and interact with their health care system.

What Will LHINs Do?

A crucial part of a LHIN's responsibility is the engagement of the entire community in defining and meeting local health priorities and needs. LHINs will not deliver health services, but will link and coordinate a range of local health care providers and providers. LHINs across Ontario will become ready access and improve the system. It will make it easier for patients and their families to connect with health services and providers along the continuum of care.

Benefits of LHINs

Health care choices by the community, for the community
Under LHINs, people close to what is really going on will identify community health care priorities at a local level.

We're all in this together
LHINs will, for the first time, involve Ontarians in the health care conversation, giving them a chance to participate in decisions about the health care system in their communities. This will give the people of Ontario true ownership of the health care system for which they pay for and depend.

Transparency, accountability and responsibility
LHINs will ensure that health care dollars are spent in the most efficient and effective way possible, yielding tangible results. Accountability agreements between health care providers and LHINs, and between LHINs and government, will ensure the responsible use of precious health care resources. LHINs will oversee the sustainability of the health care system for all Ontarians.

A system with patients at the centre
LHINs will break down the barriers that patients face navigating a complex health care system. They will ensure that decisions are made in the best interests of patient care.

For more information about LHINs, including frequently asked questions, please visit www.health.gov.on.ca/lhins

Highlights Of Local Health Integration Act

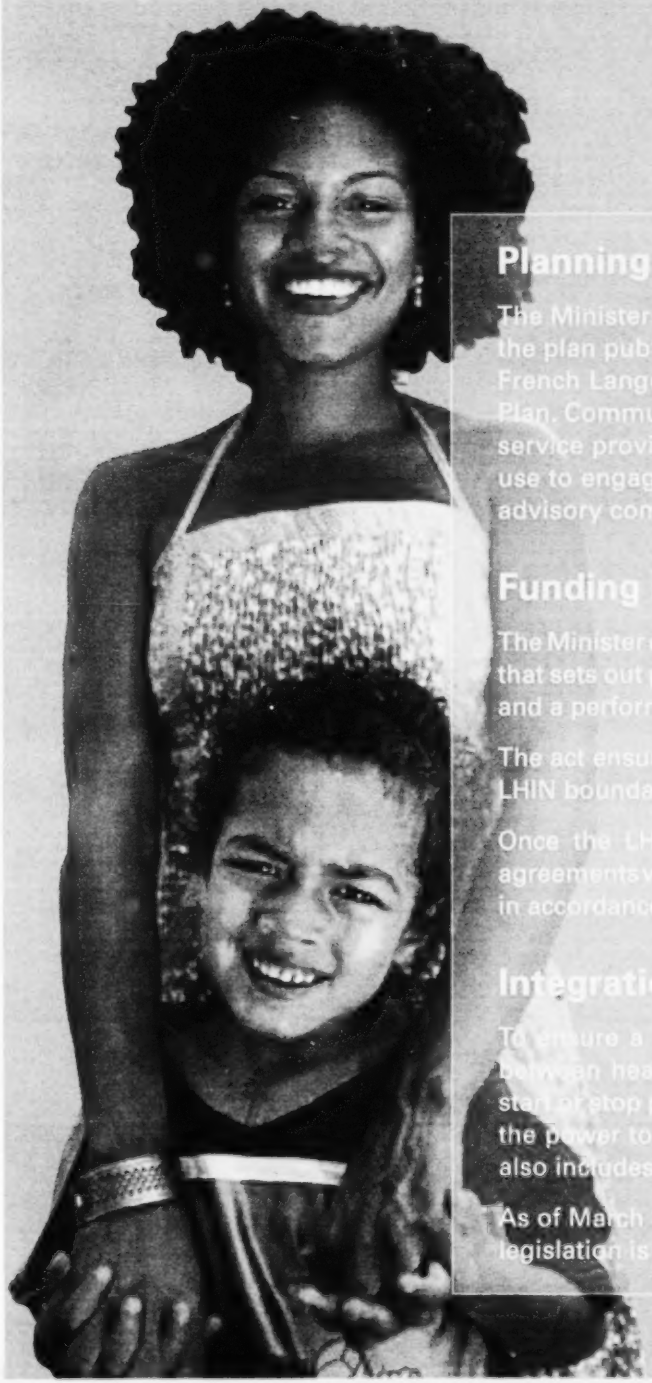
The Local Health System Integration Act, 2006 (Bill 36) was introduced on November 24, 2005 and received royal assent on March 28, 2006. The purpose of the act is to provide for an integrated health system to improve the health of Ontarians through better access to high quality health services, coordinated health care and effective and efficient management of the health system at the community level by Local Health Integration Networks.

The act establishes 14 Local Health Integration Networks (LHINs) as crown agencies of the Ministry of Health and Long-Term Care. It gives LHINs the power to plan, coordinate and fund health care providers (hospitals, long-term care homes, community support services, community health centres, Community Care Access Centres and community mental health and addictions agencies) in their specified geographic areas. It sets out the corporate organization of the LHINs, the powers of the LHIN boards of directors and requires the LHINs to have an accountability agreement with the Minister of Health and Long-Term Care.

The act provides the legislative framework for creating a health system in Ontario that is:

- Community-based, responsive to the local community about needs and priorities
- Based on Partnerships: system members (the Minister of Health and Long-Term Care, the ministry, LHINs and service providers)
- Forward Looking: emphasis on planning and priority setting
- Efficient: effective allocation of funding to achieve priorities
- Accountable: clearly defined responsibilities and measurement of achievement, monitoring and public reporting provide checks and balances in system
- Integrated: coordinated health care with focus on client needs

The act sets out certain requirements and authorities for the ministry and the LHINs in the areas of planning, community engagement, funding, accountability and integration.



Planning and Community Engagement

The Minister must develop a provincial strategic plan for the health system and make the plan public. Each LHIN is required to engage their community and Aboriginal and French Language local planning entities to develop a local Integrated Health Service Plan. Community is broadly defined in the act and includes patients and others, health service providers, and employees. The act identifies some of the methods LHINs will use to engage their communities, including community meetings, focus groups, and advisory committees.

Funding and Accountability

The Minister determines each LHIN's funding and enters into an accountability agreement that sets out performance goals and standards, reporting requirements, a spending plan and a performance management process.

The act ensures that people can access care outside of the LHIN in which they live. The LHIN boundaries do not restrict people in any way.

Once the LHINs have funding authority, they will enter into service accountability agreements with health care providers to deliver services that local communities in accordance with the LHIN's accountability agreement with the Minister.

Integration

To ensure a coordinated health system, LHINs may facilitate integration discussions between health care providers (i.e., transfer services to another location or provider, start or stop providing a service or change the amount of a service). LHINs will also have the power to require integration where they believe it is in the public interest. The act also includes mechanisms to protect employees when services are integrated.

As of March 31, not all parts of the act had been proclaimed in force. A full copy of the legislation is available on e-laws at http://www.e-laws.gov.on.ca/home.E.asp?lang=en

Table of Contents

8 Welcome to the Central LHIN

10 Message from the Chair and CEO

14 Our Leadership Team

16 Inside Our LHIN

20 Building on Success

24 Major Achievements

26 The Year in Review

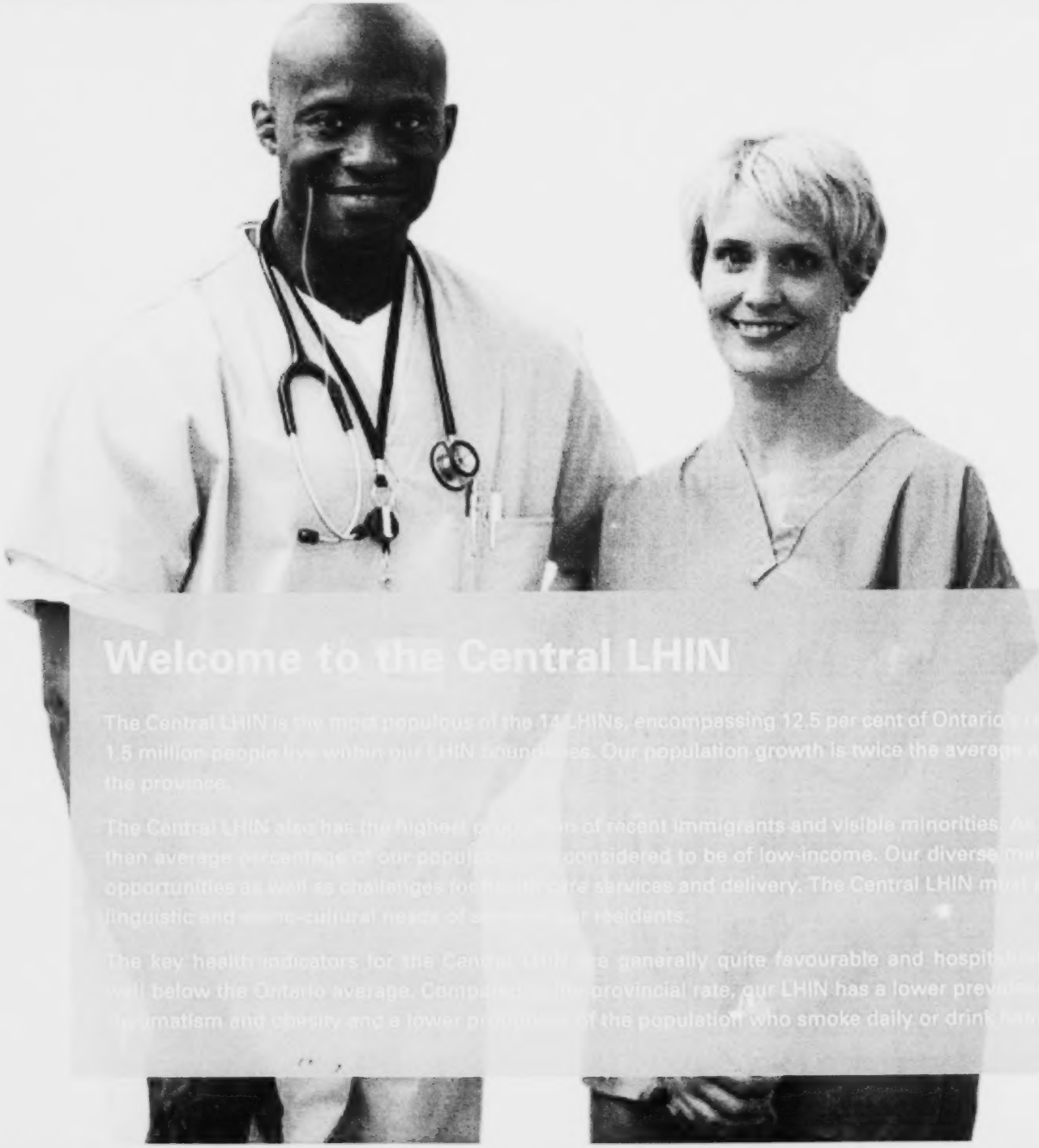
28 Governance

30 Integrated Health Service Plan

32 Community Engagement

34 Financials

38 Staff Members



Welcome to the Central LHIN

The Central LHIN is the most populous of the 14 LHINs, encompassing 12.5 per cent of Ontario's residents. Over 1.5 million people live within our LHIN boundaries. Our population growth is twice the average annual rate for the province.

The Central LHIN also has the highest proportion of recent immigrants and visible minorities. As well, a higher than average percentage of our population is considered to be of low-income. Our diverse makeup presents opportunities as well as challenges for health care services and delivery. The Central LHIN must address the linguistic and socio-cultural needs of a diverse group of residents.

The key health indicators for the Central LHIN are generally quite favourable and hospital admission rates are well below the Ontario average. Compared to the provincial rate, our LHIN has a lower prevalence of arthritis/rheumatism and obesity and a lower proportion of the population who smoke daily or drink heavily.

Central Local Health Integration Network (5)
Réseau local d'intégration des services de santé du Centre (5)
Legend / Légende
Ontario

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Ken Morrison
Board Chair

Hy Eliasoph
CEO

Message from the Chair and CEO

Building a Better Health Care System
From New Frontiers to a Promising Future

This has been a year of exploring new frontiers. It marked the inception of the 14 Local Health Integration Networks and ushered in a transformation of health care in Ontario.

The year was characterized by change at all levels. LHINs emerged at the forefront of planning and integrating health services to respond to the needs of local communities. LHIN boards assumed their role as custodians of local integration. Newly recruited LHIN CEOs assembled their leadership teams, which are focused on the evolution of the health care system. On the government level, the process has transformed the Ministry of Health and Long-Term Care from managers to stewards of the health care system.

At the Central LHIN, we are committed to building a promising future for our communities through collaboration with all of our partners, including the ministry, our health service providers and other LHINs. We are proud of what we have been able to accomplish in our first year.

We developed and implemented a Stakeholder Engagement Strategy, which is a key step in forging a truly integrated health care system. Recognizing that community engagement is essential for successfully integrating health services, we initially linked with more than 25 groups in communities throughout our area. To facilitate ongoing engagement, we have established five regional stakeholder groups to advise and assist us in reaching out to the communities we are committed to serve.

This year has seen unprecedented collaboration among many of our health service providers, including hospitals, long-term care homes, community services agencies and mental health and addiction organizations. The Central LHIN has been involved in numerous dialogue sessions involving about 100 of our health service providers to encourage and identify opportunities and initiatives to collaborate.

A key piece of the Central LHIN's work has been our focus on integrated health service planning at a local level. This is part of a provincewide planning effort by LHINs across Ontario. Our LHIN is developing an Integrated Health Service Plan (IHSP) to act as our roadmap for the future. Many groups, representing health care providers and consumers, have been brought together to address key planning priorities. Mental health and addictions, specialized geriatrics and services for seniors, chronic disease management, neurological services, wait times, hospital services and cancer care, are among the areas our LHIN communities have identified as priorities.

Several advisory groups, made up of health service providers, have also been set up to further develop our IHSP. These groups are working on strategic areas such as information management/technology and e-health, human resources and decision-making support. These advisory groups will play a key role in providing the Central LHIN with advice and guidance to ensure we are meeting our commitments across our planning priority areas. Our ultimate goals are to offer health services, which are accessible, co-ordinated, effective and efficient.

Our LHIN has made a special effort to reach out to physicians, particularly primary care doctors, to engage them in our planning efforts. We are establishing governance councils for all our health service providers to facilitate board-to-board collaboration among board chairs.

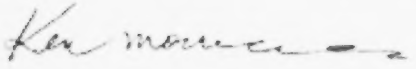
To truly build and transform the health system, we recognize that collaboration and cooperation must occur on many levels—across all the LHINs as well as working with the ministry. Staying attuned and connected to our local health care providers, is of course, paramount.

The Central LHIN is pleased to be active in building a better health system for our local residents and all Ontarians. We have provided leadership both at the board and management level to enable health service providers and users to become engaged in this crucial process.

We recognize that our efforts have only just begun. Many challenges lie ahead. However, we are confident that the health services providers within our LHIN are committed to working with us to create a better future. We share in the public's passion for building and sustaining a vibrant health system that will be there for all of our children and us. We have taken the important first steps along our journey.

We are proud to have a board with representation from virtually all areas of the Central LHIN. Collectively the board members bring together a range of health experience and community service and a commitment to improve health services. We are well positioned to provide leadership at the governance level. Our management team has extensive working knowledge of the Central LHIN, the health system in general and the planning and performance requirements needed to support our goals.

Through the partnership with our communities and stakeholders, we believe that we can improve health services for the residents of the Central LHIN and all Ontarians. We are indeed building a promising future.



Ken Morrison
Board Chair, Central LHIN

Hy Eliasoph
CEO, Central LHIN

Our Leadership Team

Ken Morrison (Newmarket)
Chairman of the Board of Directors
(Term: June 1, 2005 – May 31, 2008)

Ken Morrison is president of R.V. Anderson Associates Ltd., a consulting firm providing professional engineering, operations and management services. Morrison has a long and productive association with North York General Hospital. He joined the hospital's foundation board of governors in 1991, serving as chair of the Planned Giving Committee and then as treasurer and Finance Committee chair. In 1994 Morrison joined the hospital's board of governors and served as vice-chair from 1996-2000, before being elected to serve as chair from 2000-2005.

Arthur W. Walker, FCA (Bradford)
Vice Chair
(Term: June 1, 2005 – May 31, 2008)

Arthur Walker has extensive health care governance experience. Until recently, he served as a member of the board of directors of the Southlake Regional Health Centre and Southlake Retirement Village Inc. Walker also served as a governor/officer of North York General Hospital from 1973 to 1994 and chair of the hospital from 1982-1988. He has vast experience serving as chair, CEO or director of numerous public and private companies. Walker's current responsibilities include: chair of Calyx Transportation Group Inc., chair /CEO of Creditz Inc., director of Creation Technologies Inc. and director of CEO America Inc.

Sandy Keshen (Richmond Hill)
Board Secretary
(Term: June 1, 2005 – May 31, 2008)

Sandy Keshen is president and CEO of Reena, a social services agency that supports full community integration of individuals with developmental disabilities and their families. Keshen is co-chair of the Ontario Partnership on Aging and Developmental Disabilities. Keshen has served as chair of the Metro Agencies Representative Council and chair of the Ontario Association on Developmental Disabilities. Keshen was also a board member at Whitby Psychiatric Hospital and a member of the Vaughan Hospital Task Force.

Colin J. Benjamin (North York)
(Term: January 5, 2006 – February 4, 2008)

Colin Benjamin is currently the vice-chair of CareWatch Toronto, a voluntary organization dedicated to ensuring the quality of community-based long-term care. Prior to his retirement, he served as assistant vice-president, research administration at the University Health Network. He holds a master's degree in health services administration from the University of Kings College/Canadian School of Management. He is a member of the Canadian College of Health Executives and the Society of Research Administrators. He has served on the former City of North York Board of Health and the North York Community Care Access Committee. He has been the recipient of a WHO Fellowship to the Armed Forces Institute of Pathology, Washington DC, the Editor's Award of the Journal of Histotechnology and the Surgipath Canada Award of Excellence.

Anne Marie Dalimonte (Vaughan)
(Term: January 5, 2006 – February 4, 2008)

Anne Marie Dalimonte was vice-president of a retail food chain for 17 years. For the past 11, she has served as the executive director of a not-for-profit day care, which caters to over 500 families. Dalimonte has served on a range of community organizations: president of a parent-teacher association, vice-president of a figure skating club and a member of her local ratepayers' group. A business graduate, Dalimonte was one of just 25 Canadian representatives at the Duke of Edinburgh's Commonwealth Study Conference in 1992.

Dr. Monique Moreau (Everett)
(Term: January 5, 2006 – February 4, 2007)

Monique Moreau has been a family physician in Alliston since 1997. Moreau's other professional activities include, serving as a coroner and an examiner for the College of Family Physicians of Canada, as well as surveying for the Canadian Council on Health Services Accreditation. Moreau has taught family medicine at the University of Toronto. She has served on a number of boards, including Stevenson Memorial Hospital 2003-2006, St. Michael's Halfway Homes in Toronto and Les Résidences Communautaire Lynne Ferguson Inc. in New Brunswick.

Hy Eliasoph (Thornhill)
CEO

Hy Eliasoph was most recently a director with the national health services consulting practice of Deloitte Inc., working across Canada with hospitals, regional health authorities, ministries/departments of health, Community Care Access Centres, provincial and national associations and private sector organizations.

Prior to joining Deloitte, Eliasoph was the director of strategic health policy at the Ontario Hospital Association (OHA) and served as the first executive director of the Ontario Joint Policy and Planning Committee (JPPC). He also worked in several diverse portfolios at the Foothills Medical Centre in Calgary.

Eliasoph holds a master's degree in planning from the University of Alberta. He is a part-time faculty member at the University of Toronto, Department of Health Administration and is a certified and active member of the Canadian College of Health Services Executives.

Annual Board Remuneration

The aggregate remuneration for members of the board of directors for fiscal 2005/06 was $30,630.

Three additional board members have been identified through the board community-based nomination process and are awaiting confirmation by order-in-council.

Our population

Central is the most populous LHIN in Ontario. Our communities are home to over 1.5 million residents. Our population resides primarily in neighbourhoods in the north end of Toronto, the suburban communities north of the city commonly known as the "905" area and along the Highway 400 corridor. During the years, 1994-2004 our population grew, on average, by 3.1 per cent each year. This was much greater than the 1.5 per cent annual increase seen in Ontario during the same period.

The Central LHIN is home to many of Ontario's most diverse communities. We have the highest proportion of immigrants--newcomers as well as those who made a home for themselves here many years ago. A large percentage of visible minorities also reside in some of our communities. Recent immigrants make up 10 per cent of the Central LHIN's population - double the provincial average.

Newcomers are concentrated in certain municipalities in our LHIN, particularly Toronto, Richmond Hill, Markham and Vaughan. These areas also house the highest number of people whose mother tongue is neither English nor French. The highest proportion of visible minorities, also reside in these communities, contributing to the diversity, complexity and vibrancy of our region.

Our LHIN has a slightly lower proportion of seniors and children than the provincial average. Seniors 65 years or older make up 13 per cent of Ontario's population, compared to the Central LHIN's 11 per cent. In fact, all of the Central LHIN's communities are below the provincial average except for Tecumseth and Toronto. Bradford West Gwillimbury and Essa are notable as communities with the lowest percentage of seniors. Generally it is in our high population density areas where the majority of seniors and children (individuals age 20 or younger) reside.

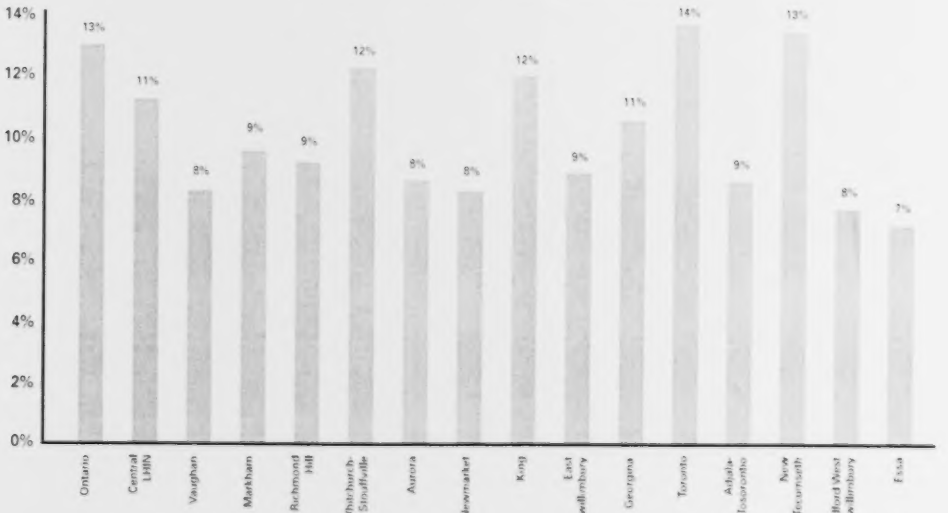
It also should be noted that the Central LHIN has significant numbers of low-income residents. The percentage is slightly higher than the provincial average. Many of our low-income dwellers are concentrated in communities in the north end of Toronto and a number of our remote rural areas. Income level can be a determining factor of health status and outcomes.

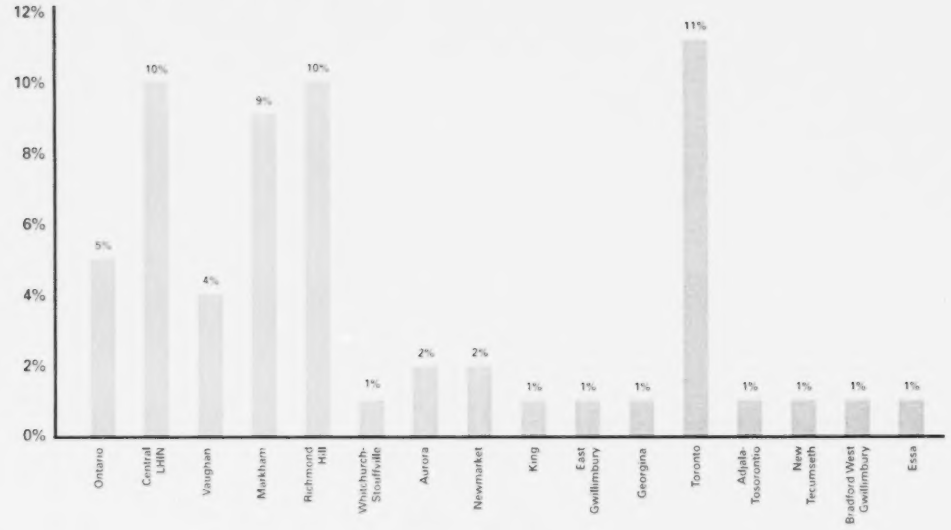
Population (65+)

Population (65+)

Population Density (<20)

Percentage of Population Age 65+

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East Gwillimbury
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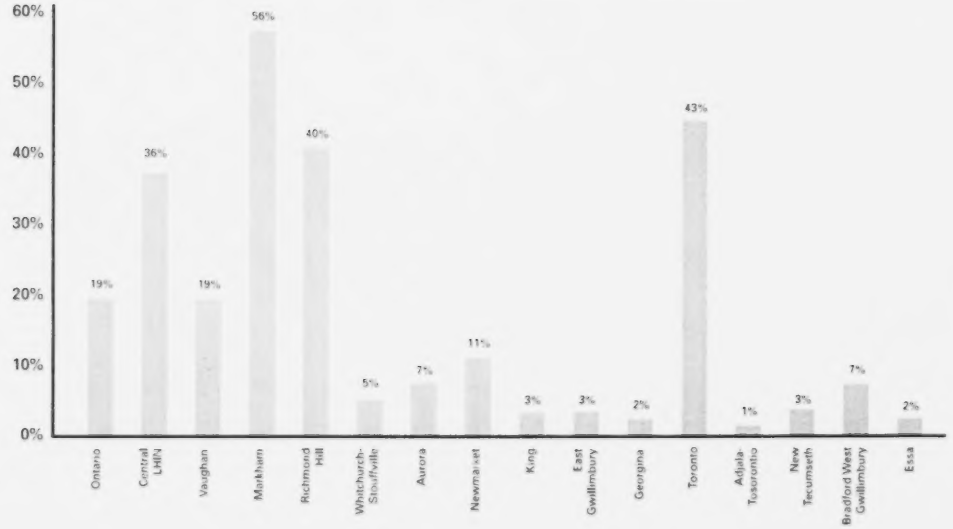
New Tecumseth
Bradford West Gwillimbury
Essa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Essa

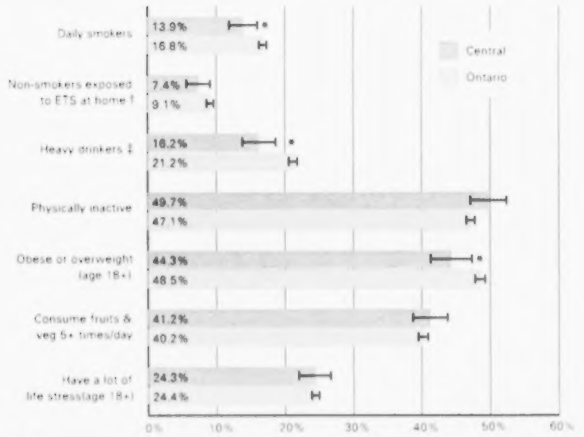
Health Status

The residents in our communities generally demonstrate many positive characteristics of health status. The prevalence of certain chronic illnesses, like arthritis and rheumatism, is lower in the Central LHIN than the provincial average. Hospitalization rates in our LHIN are also below the Ontario average. This tends to be indicative of a healthier population. Fifty-nine per cent of the Central LHIN residents rate their overall health as excellent or very good. This is similar to the provincial average. However, it is interesting to note that only 19 per cent—the lowest proportion in Ontario—report being limited in their activities due to a prolong physical or mental condition.

Health Practices & Preventive Care

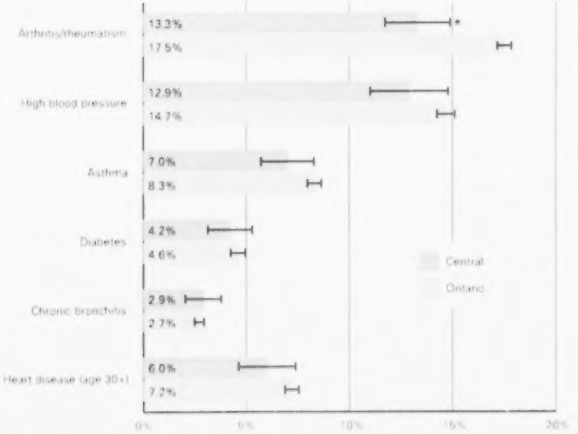
Residents in our communities generally practice positive healthy behaviours. The Central LHIN's population partakes less in daily smoking and heavy drinking. Our LHIN also has a lower proportion than the provincial average of individuals who are considered to be overweight or obese. This likely contributes to the lower than average incidence of certain chronic illness and below average hospitalization rates in our LHIN. Our residents also make use of preventative health care services, like getting flu shots, at a rate similar to the provincial average.

Health practices, population age 12+



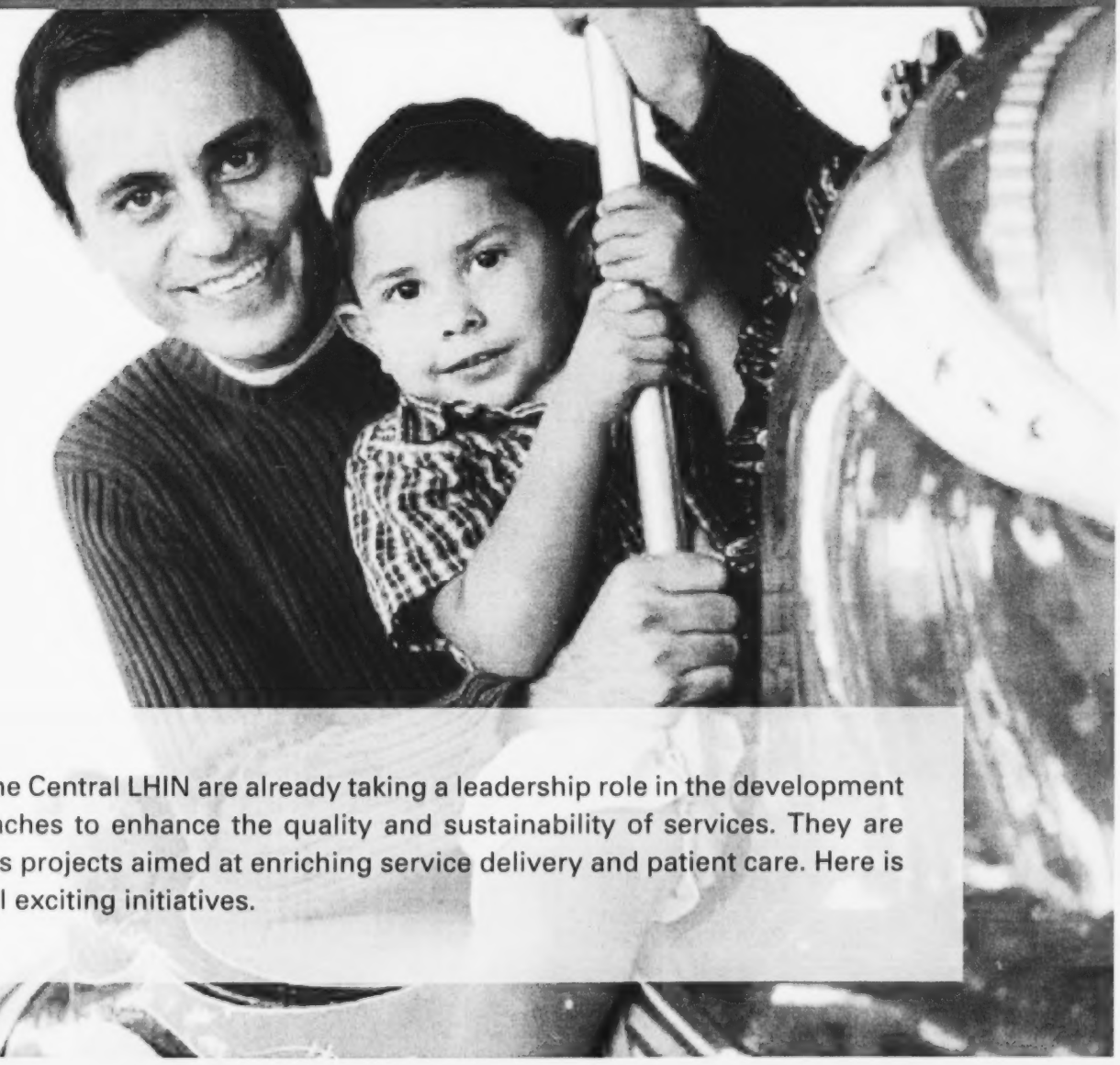
† ETS - environmental tobacco smoke (second-hand smoke)
‡ as a proportion of current drinkers
* Significantly different from provincial average based on assessment of 95% confidence interval
Data Source: Canadian Community Health Survey, 2003

Prevalence of selected chronic conditions, population age 12+



Significantly different from provincial average based on assessment of 95% confidence interval
Data Source: Canadian Community Health Survey, 2003

Building on Local Success



Health providers in the Central LHIN are already taking a leadership role in the development of innovative approaches to enhance the quality and sustainability of services. They are involved in numerous projects aimed at enriching service delivery and patient care. Here is a sampling of several exciting initiatives.

Organization	Project
Meeting community needs through integrated care	
A Joint Partnership between York Central Hospital and Ontario March of Dimes	This partnership provides support to individuals who live with the effects of an acquired brain injury
Across Boundaries: An Ethnoracial Mental Health Centre	Holistic Model of Mental Health Care Within an Anti-Racism Framework
CMHA-York Region	Streamlined Access to Mental Health Case Management in York Region
Humber River Regional Hospital	An Integrated Primary Care Program
Humber River Regional Hospital	Hypertension Outreach Program
Humber River Regional Hospital	Children's Health Care Fairs
Humber River Regional Hospital (HRRH), Mental Health Program	Joint Community Support Partnership Between Canadian Mental Health Association (CMHA), Reconnect Mental Health Services (Reconnect) and Humber River Regional Hospital (HRRH)
Humber River Regional Hospital, Child & Adolescent Mental Health Program	Transition Support Partnership between Humber River Regional Hospital (HRRH) Child/Adolescent Program and The Griffin Centre
Saint Elizabeth Health Care	Cardiovascular Telemonitoring "Home Early" Program
Improving Quality And Patient Safety	
Aphasia Institute	Supported Conversation for Adults with Aphasia - Increasing Communicative Access to Healthcare
Humber River Regional Hospital	"Hug & Hold" - parents to be present and participate in the Operating Room (O.R.) during the anesthetic induction of their child by providing emotional and physical support
Humber River Regional Hospital	Nocturnal Home Hemodialysis
Humber River Regional Hospital, Church Site	The Use of Sodium Citrate 4% Instead of Heparin 10000 U/mL as a Locking Agent for Central Venous Hemodialysis Catheters - A Retrospective Analysis
Ministry of Health and Long-Term Care	Partners in Prevention - Ministry of Health and Long-Term Care and Ontario Provincial Police
Yee Hong Centre for Geriatric Care	The ABCs of BPGs: A Workbook to Facilitate Nursing Staff's Understanding of Best Practice Guidelines
York Support Services Network	Consumers as evaluators in consumer satisfaction evaluation
Improving Efficiency Through Process Redesign	
COTA Health, in collaboration with Campana Systems Inc.	Improving Administrative Efficiency and Accuracy through the Use of a Web-Enabled Application
Newmarket Health Center	Resident Diet Cards
North York General Hospital	Surgical Program Patient Flow
Southlake Regional Health Center	Regional PCI Project - to standardize care relating to pre/post PCI (Percutaneous Coronary Intervention) care across the region
York Central Hospital	Strengthening the Continuum of Care for Patients Undergoing Joint Replacement
Innovations In Health Human Resources	
Bayview Community Services Inc.	Back to the Future: Organizational Design That Improves Staff Retention and Effectiveness, The Basics We Cannot Afford to Forget
Child & Adolescent Mental Health Program, Humber River Regional Hospital (HRRH)	A Participatory Action Methodology for Community Education in Child & Adolescent Mental Health

"An Integrated Primary Care Program"

Developing closer links between family physicians and hospitals is an important step in the creation of a truly integrated health care system. Humber River Regional Hospital, working in partnership with family physicians, developed an innovative program to provide more integrated care to patients. The hospital initiated the first integrated primary care program model in Ontario. The objective was to better integrate family practice into the hospital.

An enhanced communication strategy was developed between family physicians and the hospital. A quality assurance process was introduced as well as rules and regulations for family practice.

The program achieved tangible results in improving communication between family physicians and the hospital. Seventy per cent of family physicians now have remote computer access through Medical Information Technology Inc. (MEDITECH) to obtain patient results at the hospital. There also has been a 20 per cent increase in the number of family physicians with privileges at Humber River Regional Hospital. Monthly business meetings are being held in the community with 30 to 40 physicians in attendance.

The hospital is now investigating the development of a shared model between family practice and nephrology (the treatment of kidney functioning and disease) as well as the psychiatry department.

"Surgical Program Patient Flow Initiative"

Managing patient flow can be the key to efficient use of precious hospital resources. With this in mind, North York General Hospital developed an initiative with the goal of improving patient flow through the surgical system. The hospital committed to minimizing the barriers that impeded the smooth flow of patients from admission to discharge.

By reducing transfer times, cancellations and facilitating more timely transfers of patients out of critical care, the hospital showed dramatic improvements in managing its surgical resources.

Between April 2005 and March 2006, operating room on hold time was reduced nearly 50 per cent. Monthly cancelled surgical cases were also cut in half. Wasted capacity in the post-anesthesia care unit was lowered from 100 to 85 hours per month and unit-based transfer times fell from 40 to less than 15 minutes.

Between April 2005 and March 2006, operating room on hold time was reduced nearly 50 percent.

Improving patient flow is a continuous process requiring ongoing commitment by the institution, said Nancy McNairn, program director of surgical services at North York General Hospital. "We're doing twice as many joint surgeries as we did two or three years ago, without an increase in beds," McNairn noted.

Many stand to gain from the success of the surgical patient flow initiative. It maximizes the hospital's use of critical resources and improves efficiency. It can also enhance access to care and heighten patient satisfaction.

"Supported Conversation for Adults with Aphasia"

Patients suffering from brain injuries can find themselves living in isolation and frustration, when they are suddenly robbed of their ability to communicate and express themselves. Aphasia is the loss of ability to readily understand or express speech and it can follow a serious trauma to the brain.

The Aphasia Institute, located in Toronto, has developed an innovative system that uses verbal and non-verbal materials to aid in communication for patients with brain injuries that interfere with normal verbal communication. More than 25 years old, the institute provides direct services and programs as well it offers education training and conducts research.

The Aphasia Institute's system can play a key role in strengthening the rights of vulnerable patients by enhancing their access to health services and improving their ability to participate in their own care. Improving a patient's ability to communicate helps them to more readily form and recover their social connections.

Dr. Mark Bayley, medical director of the Neuro Rehabilitation Program at the Toronto Rehabilitation Institute, praised the work of the Aphasia organization.

"The Aphasia Institute provides an opportunity to better understand the process of recovery for individuals with stroke," said Bayley, who is also an assistant professor at the University of Toronto. "As a researcher in the field of stroke, we have recently highlighted that community re-integration is a key gap in services and rehabilitation research knowledge," Bayley said.

From a clinical perspective, the Aphasia Institute's system can help reduce diagnostic and treatment errors. If a patient can more readily communicate with medical staff there is a greater ability to gather important clinical information, using a relatively affordable and low-tech system.

In the past year, the Aphasia Institute served about 150 clients who live in the Central LHIN. It also trained about 100 volunteers from our community to help support the efforts of those struggling to communicate.

Major achievements

The leadership of the Central LHIN recognized that planning for a local health system must be centred on the needs and abilities of the area's consumers and service providers.

In 2005/06 our LHIN engaged extensively with both of these groups to ensure that our Integrated Health Service Plan (IHSP) is a true reflection of the most appropriate health system for our 1.5 million residents.

Communication with our community and our stakeholders has been a key goal. To support this, our LHIN organized dialogue sessions with about 100 health care provider organizations. The links forged with the leadership of these organizations generated a continuum of issues and priorities for our LHIN to address. We also reconvened the original Central LHIN Steering Committee and validated the relevance and importance of the initial priorities this group had earlier identified.

To maintain the lines of communication, health provider organizations in the Central LHIN were invited to forward all relevant information and documents, including strategic plans, for further input into our planning process and to ensure that we continue to build upon existing efforts.

Another key development was the establishment of five geographic regional stakeholder groups, composed of community leaders. These groups will help us to better identify the most informed players from which our LHIN should seek input on the local health system. Recognizing the central role consumers will play in shaping our new health care system, the Central LHIN held 28 stakeholder sessions with over 400 participants to include their voices on the current local successes and failures.

As we actively engaged our communities, we also established numerous planning groups, involving both consumers and health service providers to focus on specific Central LHIN priorities. These key priorities include mental health and addictions, seniors and geriatrics, chronic illness, neurological services, coordinated waiting list management and cancer services. In addressing the key strategic elements, our LHIN identified common recurring concerns or threads that link the priorities. The common concerns point to the collective pieces of the puzzle required to create a truly integrated health system: access, coordination, effectiveness and efficiency.

We have established, or are in the midst of setting up, advisory groups to address each connective piece of the puzzle. The goal is to gain input into how best to ensure that these key elements are incorporated into our IHSP for each priority area.

Finally, we recognize that a transformed health system will require new approaches on how to integrate services for seamless delivery of care. The Central LHIN has established three advisory groups comprising a cross-section of our service provider organizations to seek new collaborative solutions in the following areas: information management, information technology and e-health, health human resources and decision-making support.

The Central Local Health Integration Network: *The Year in Review*

Objectives And Accomplishments

We are proud that the Central LHIN accomplished all of the performance objectives outlined in our 2005/06 Memorandum of Understanding with the Ministry of Health and Long-Term Care.

The key achievements included orientation and support for the six current board directors and recommendation of the final three board members. The set up of our LHIN office was completed, including the selection of senior management staff and support staff.

Engagement with health care providers and the community were key parts of our LHIN meeting its mandate. Further, the Central LHIN has developed and partially implemented Phase I and II of our Stakeholder Engagement Strategy. Again, this strategy was created through extensive community input. This consultative approach also fuelled the development of a comprehensive and well-documented roadmap for the creation of our first Integrated Health Service Plan.

On a management level, we have established key policies and procedures specific to the operation of the Central LHIN. On the provincial front, our LHIN has made significant contribution to the ministry's e-Health Strategy and has shown leadership in advancing the provincial Wait Time Strategy.

Operational Startup

Once the policy framework was established by the Ontario government and Local Health Integration Networks were chosen as the model for integration, there was much work to be done. First, it was time to launch LHINs as 14 crown corporations. In June 2005, 14 news conferences were held across the province to publicly announce the 14 LHINs chairs, 42 founding board members and 14 CEOs.

CEOs began work in August 2005 and worked alongside the board chairs to increase their knowledge of the communities they serve. LHIN leaders hosted 37 'meet and greet' sessions across the province with 1,500 leaders of health care organizations during the summer of 2005.

Fourteen offices were set up in Ontario. To ensure cost-effective and efficient operations, LHINs established a common administration process to deliver payroll, financial and human resource services for all the LHINs.

LHIN offices were open and ready-for business by the fall of 2005. Four staff members were recruited in each LHIN. The Central LHIN leadership team was in place by January 2006. Plans to recruit additional staff are underway.

A business operations manual was created to provide basic policies and procedures related to LHIN business operations. This included government directives that LHINs must follow, a summary of legislative requirements that govern LHIN practices and standard policies and activities required by the ministry for all LHINs.

Extensive orientation sessions were held in 2005 for the founding LHIN board members and staff. As part of their professional development, LHINs and the ministry hosted several 'think thanks' on topics such as funding models, planning, corporate governance, ethics and a framework for ethical decision-making. Discussion forums were held to tackle such issues as physicians' relationships with LHINs and LHIN cross-boundary issues.

Accountability agreements between each LHIN and the ministry were developed for the years 2005/06 and 2006/07, setting out the key activities for which the LHINs are responsible. LHINs received templates and guidelines for filing quarterly reports to the ministry.

Governance

Board Development And Structure

The board of directors is responsible for overseeing the affairs of the Central LHIN so as to fulfil its mandate and responsibilities. These are set out in its letter patent, bylaws, approved business and strategic plans, the relevant government and ministry directives, guidelines, policies and procedures set out in the Memorandum of Understanding. The board must also adhere to any performance agreement with the minister or any responsibilities that may be established and communicated by the minister to the LHIN.

The board, through the chair, is accountable to the minister for the LHIN's use of public funds and for results in terms of goals, objectives and performance of the local health system.

The ministry has provided LHINs with extensive guidelines to support board development. The chair of the Central LHIN has followed these guidelines, such as the "Governance Manual for Board Directors". This led to the successful establishment of the vice-chair, secretary and three member positions. In addition, the process to nominate the final three members has been completed.

The board has been meeting monthly since July 2005 to both attend to board business and undertake education related to the operations of the Central LHIN. The board has been undertaking extensive activities to finalize a strategic vision for our LHIN. A draft document outlining this vision will be reviewed with health service providers, consumers and residents of the Central LHIN.

Committees Established

Under authority of the Central LHIN board bylaw, in 2005, the board established an interim Officers/Executive Committee. This committee met through to year-end. In addition, a temporary Nominations Committee was formed for the purpose of identifying the final three board members. A motion was passed in March 2006, to create an Audit Committee and work has begun on establishing the terms of reference.

Orientation Activities

A comprehensive board orientation package was developed by the Central LHIN and presented to the board on February 15, 2006. Each of the six directors was also provided with the Governance Manual and the LHIN briefing documents produced by the ministry. There have been frequent education sessions for board members. As well, the original six directors have participated in an in-depth visioning and strategic planning exercise.

Community-based Recruitment

Consistent with the ministry's comprehensive "Instructions for Recruiting Community-based Board Members" the board of the Central LHIN initiated a Nominations Committee in September 2005. The board then carried out a comprehensive nominations process to select the three remaining directors from the community. Three public information sessions were held and the Nominations Committee reviewed almost 80 applications. From these, 14 candidates were interviewed and candidates recommended to the minister.

Performance Agreement

The Ministry of Health and Long-Term Care continues to set priorities for improving the health care of all Ontarians. The ministry also outlines the principles, goals and requirements for all LHINs to ensure that all Ontarians have access to a consistent set of health care services.

The relationship between the government and each LHIN (including operational, financial, auditing and reporting) is outlined in a Memorandum of Understanding and an annual Performance Agreement between each LHIN and the Ministry of Health and Long-Term Care.

The Central LHIN and the ministry signed the 2005/06 Performance Agreement and our LHIN has fulfilled all the obligations in that agreement.

Conflict Of Interest Guidelines

The Ministry of Health and Long-Term Care has provided LHINs with conflict of interest guidelines.

CEO Performance Evaluation

The Central LHIN board has established a process and a framework for goals and objectives upon which to evaluate the Central LHIN CEO, based in part on the Memorandum of Agreement and Accountability Agreement with the Ministry of Health and Long-Term Care.

Integration Priorities

The Central LHIN has identified a number of key areas to focus on for our first Integrated Health Service Plan. Senior care and geriatrics, mental health and addictions and the management of chronic illness were the top three priorities, which arose from a consultation process with both health care providers and consumers.

We have structured our ongoing engagement activities to ensure that we continue to gather input on current successes, failures and improvement strategies relating to these priority areas. The comprehensive process, which led to our LHIN identifying key priorities, is described in further detail below.

Integrated Health Service Plan

Keeping Ontarians healthy, reducing wait times and providing better access to doctors and nurses are the three goals of the Ontario government's health strategy.

To support the achievement of these goals, in October 2006 the Central LHIN will submit our first Integrated Health Service Plan (IHSP) to the Minister of Health and Long-Term Care. This plan will set out our priorities and strategies for the next three years — from April 2007 to March 2010.

Our Integrated Health Service Plan will include a profile of the Central LHIN's diverse communities and population demographics, a description of the existing health services within the LHIN as well as an overview of current Ontario government health priorities. Our IHSP will also focus on the Central LHIN's current activities for planning and engaging with our communities. It will set out our priorities for changes we want to introduce within the Central LHIN and contain an action plan covering a three-year period.

To support the development our IHSP, the Central LHIN is currently engaging in a process to help us better understand the current state of health services in our local area.

We are talking with health service providers and consumers. We want to hear what they have to tell us about challenges as well as the best practices and opportunities that can strengthen health services within the Central LHIN. These dialogues will assist us in creating a comprehensive baseline of existing services according to type, method and frequency of delivery.

More than 130 agencies in the Central LHIN receive funding from the government to provide health care services. For health planning purposes, we are looking at Community Care Access Centres, community health centres, community support services, hospitals, long-term care homes and mental health and addiction services.

The stakeholders in the Central LHIN are helping to develop the IHSP. Over 300 health care consumers and providers are working on our IHSP priority planning and advisory groups. More than 50 people are involved in specific IHSP development projects. They are helping us with the community engagement process and establishing information requirements.

Physicians' services are not part of the LHINs' planning mandate. However, doctors are a critical component of our local health system. The Central LHIN is working with physician groups to establish ongoing dialogue. Doctors also participate on our planning and advisory groups.

Our first Integrated Health Service Plan will address the following priority areas:

Seniors Services/Specialized Geriatrics

We are looking at the continuum of care for community support services and working with consumers and providers to strengthen the delivery of specialized geriatrics.

Mental Health and Addictions

We are developing a delivery framework for mental health and addictions services in the Central LHIN.

Chronic Disease Management

We are developing a framework for chronic disease management and prevention.

Neurological Services

Consumers and service providers are working together to eliminate gaps in the system.

Cancer Services

Working collaboratively with Cancer Care Ontario, we are supporting a LHIN-wide initiative to coordinate services and build capacity for cancer services. We want to ensure that the new regional cancer centre serves the residents of the Central LHIN and beyond.

Wait Times

We are bringing together key providers to build capacity to reduce wait times for the following procedures: hip and knee replacements, cataracts, MRIs, cancer services, and cardiac services.

Hospital Services

We are working with all the hospitals in the Central LHIN to identify their priorities that can be incorporated into the IHSP.

For each of the priority areas, we will be overlaying a series of interlocking streams that will run throughout the Integrated Health Service Plan. We will focus on access to services and care for the people needing the services and care. We will encourage coordination among providers to ensure people who need more than one service can access them in a 'seamless' manner. Our goal is for health care services provided within our LHIN to be effective, in terms of excellence in quality and appropriateness in outcomes. The Central LHIN is also making a commitment to efficiency of service provided in a cost-effective manner.

We have also established, or will soon be setting up, advisory groups with representation from our local stakeholders to look at a number of areas that will foster integration of health care services. These include a focus on information technology, information management and e-Health, human resources, decision-making support as well as family medicine and primary care.

The three-year IHSP is a 'rolling' plan and each year we will evaluate our progress, update our plan and start a new cycle of identifying and implementing priorities. In consultation with health care consumers and health care providers, we will add other priorities in successive plans. From feedback in our consultations with consumers and service providers, we are confident that the initial set of IHSP priorities offers real opportunities to improve the quality of care for people in the Central LHIN.

Community Engagement

Community Engagement Plan, Strategies, Activities

In August and September 2005, the board members and CEO held 30 individual 'meet and greet' sessions with local health service providers as well as three public information sessions. This was an opportunity to introduce the Central LHIN's senior leadership to our communities and begin the important process of substantive and meaningful stakeholder engagement. The Central LHIN connected with over 650 people in our communities from August 2005 to March 31, 2006. This included 'meet and greets', presentations with the management and staff in our service provider organizations and meetings with community and consumer groups.

In January 2006, a draft Stakeholder Engagement Strategy (SES) was developed and distributed for feedback to more than 200 stakeholders in the Central LHIN. It included goals, objectives and principles. It proposed approaches and methods to ensure ongoing comprehensive stakeholder engagement. Over 30 stakeholders provided feedback on the appropriateness of the draft strategy in February 2006. This was incorporated into a final strategy, which was then sent to all stakeholders.

One of the key elements of the SES was the establishment of five regional stakeholder groups, representing the five major geographic areas of the Central LHIN. These groups have been instrumental in identifying many health interest groups in communities throughout the Central LHIN. Having identified these groups, in March 2006, we met with more than 400 residents in 28 separate sessions in several communities throughout the Central LHIN. We asked participants some key questions. What is working well in the health system? What isn't working well? What are your priorities?

A number of key themes emerged from our consultation with our stakeholders. Access and responsiveness of services were running threads in a number of issues and challenges raised. Stakeholders called for greater access to physicians, diagnostics prevention and recovery supports such as rehabilitation, diabetes education, prevention of falls and wellness programs. They pointed to after-hours clinics and a 24-hour telephone medical advice service, like Telehealth Ontario, as useful options to improve access.

Stakeholders want to see provision of services that are responsive to the population, including being sensitive to linguistic and ethno-cultural needs. As well, stakeholders want increased ease in navigating services. They want to know what services are available and where to find them.

There were calls for more caring in the system, particularly as it relates to senior and youth 'friendly' services. Stakeholders also spoke of the cost and distance of transportation as being possible barriers to services.

The input gained from our communities and stakeholders will prove invaluable as we move forward to better integrate our health care system.

Community Engagement – Aboriginal And First Nations

Linkages were made with the Aboriginal Resource Council for York Region in March 2006, to discuss methods to engage the Aboriginal community. It was decided to hold sessions later in the spring of 2006 to coincide with Phase III of the Central LHIN's Stakeholder Engagement Strategy.

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Auditors' Report

To the Members of the Board of Directors of the
Central Local Health Integration Network

We have audited the statement of financial position of Central Local Health Integration Network ("LHIN") as at March 31, 2006 and the statements of operations and changes in net assets for the period from the date of incorporation June 2, 2005 to March 31, 2006. These financial statements are the responsibility of the LHIN's management. Our responsibility is to express an opinion on these financial statements based on our audit.

We conducted our audit in accordance with Canadian generally accepted auditing standards. Those standards require that we plan and perform an audit to obtain reasonable assurance whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation.

In our opinion, these financial statements present fairly, in all material respects, the financial position of the Central Local Health Integration Network as at March 31, 2006 and the results of its operations and its cash flows for the period from the date of incorporation June 2, 2005 to March 31, 2006 in accordance with Canadian generally accepted accounting principles.

Deloitte & Touche LLP

Chartered Accountants

Toronto, Ontario
May 29, 2006

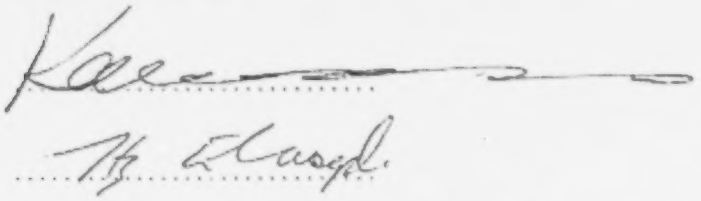
Member of
Deloitte Touche Tohmatsu

Statement of Financial Position

As at March 31, 2006

Assets	
Cash	$ 33,376
Capital assets (Note 3)	1
	$ 33,377
Liabilities and Net Assets	
Accounts payable and accrued liabilities (Note 4)	$ –
Net Assets	33,377
	$ 33,377

Approved by the Board



Statement of Operations and Changes in Net Assets

Period from the date of incorporation June 2, 2005 to March 31, 2006

Revenue	
Ministry of Health and Long Term Care ("MOHLTC") Funding	$ 7,770
MOHLTC payroll reimbursement	221,405
	229,175
Expenses (Note 5)	
Salaries and benefits	$ 192,496
Office supplies	298
Catering	2,520
Other	484
	$ 195,798
Excess of Revenue over Expenses	$ 33,377
Net Assets. Beginning of Period	–
Net Assets, End of Period	$ 33,377

Notes to the Financial Statements

1. Description Of Business

Formation and status
The Central Local Health Integration Network was incorporated by Letters Patent on June 2, 2005 as a corporation without share capital. Following Royal Assent to Bill 36 on March 28, 2006, it was continued under the *Local Health System Integration Act, 2006* (the "Act") as the Central Local Health Integration Network (the "LHIN") and its Letters Patent were extinguished. As an agent of the Crown, the LHIN is not subject to taxation.

The LHIN is, and exercises its powers only as, an agent of the Crown. Limits on the LHIN's ability to undertake certain activities are set out in both the Act and the Memorandum of Understanding between the LHIN and the Ministry of Health and Long-Term Care (the "MOHLTC"). Funding of the LHIN by the MOHLTC in the fiscal year ended March 31, 2006 was made pursuant to the terms of a Performance Agreement.

LHIN operations
The objects of the LHIN are to plan, fund and integrate the local health system within its geographic area. The LHIN spans carefully defined geographical areas and allows for local communities and health care providers within the geographical area to work together to identify local priorities, plan health services and deliver them in a more coordinated fashion. The Central LHIN boundaries include a nothern section of the City of Toronto, most of York Region, and part of Simcoe County.

Fiscal period
These financial statements represent the activities of the LHIN from June 2, 2005, the date of incorporation, to March 31, 2006.

2. Significant Accounting Policies

Financial statement presentation
The financial statements have been prepared in accordance with the accounting standards for not-for-profit organizations published by the Canadian Institute of Chartered Accountants using the deferral method of reporting restricted contributions.

Revenue recognition
Ministry of Health and Long-Term Care funding is recognized as revenue in the year in which the related expenses are incurred. Any designated funds for which the expenses have not been incurred are recorded as deferred revenue.

Use of estimates
The preparation of financial statements in conformity with Canadian generally accepted accounting principles requires management to make estimates and assumptions that affect the reported amount of assets and liabilities, the disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates.

3. Capital Assets

The LHIN office maintains a record of assets purchased on its behalf by the MOHLTC. The nature of these assets includes:

- Leaseholds (arranged by Ontario Realty Corporation)
- Furniture and equipment
- Computer software and equipment

These assets have been reflected at a nominal dollar value of $1, as the payments for these assets have been included in the expenditures of the MOHLTC.

4. Accounts Payable And Accrued Liabilities

The MOHLTC has included accounts payable and accrued liabilities totaling $198,166 in its records on behalf of the LHIN as at March 31, 2006. These expenses are included in amounts disclosed in Note 5.

5. Expenses

All other operating expenses, other than those disclosed on the statement of operations, were approved and paid for on behalf of the LHIN by the MOHLTC. These expenses for the period ended March 31, 2006 are as follows:

Salaries and benefits	$	139,938
Accommodation/occupancy		1,128,209
Common services		42,126
Information technology		100,609
Other expenditures		388,803
	$	1,799,685

6. Guarantees

(i) The LHIN is subject to the provisions of the *Financial Administration Act*. As a result, in the normal course of business, the LHIN may not enter into agreements that include indemnities in favour of third parties, except in accordance with the *Financial Administration Act* and the related *Indemnification Directive*.

(ii) An indemnity for the Chief Executive Officer was provided directly by the LHIN. Between March 28, 2006 and March 31, 2006, the directors, officers and employees of the LHIN received the benefit of Section 35 of the Act.

7. Statement Of Cash Flows

A statement of cash flows has not been provided, as the information it would contain is readily determinable from the accompanying statements.

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